CDC

July 27, 2001 / Vol. 50 / No. 29

MMWR™

MORBIDITY AND MORTALITY
WEEKLY REPORT

617 West Nile Virus Activity — Eastern United States, 2001
620 Global Progress Toward Laboratory Containment of Wild Polioviruses, June 2001
623 Heat-Related Deaths — Los Angeles County, California, 1999–2000, and United States, 1979–1998

West Nile Virus Activity — Eastern United States, 2001

In 2000, ArboNET, an enhanced human and animal surveillance system designed to monitor the geographic spread of West Nile virus (WNV) in the United States and to identify areas at increased risk for human infections with WNV, detected WNV activity in the District of Columbia and 12 states (*1*). This system, first implemented in the District of Columbia and 20 states along the Atlantic and Gulf coasts, was later expanded throughout the continental United States. This report summarizes ArboNET data from January 1 through July 25, 2001, which documents epizootic WNV activity in the southeast and indicates the need for widespread implementation of WNV prevention activities.

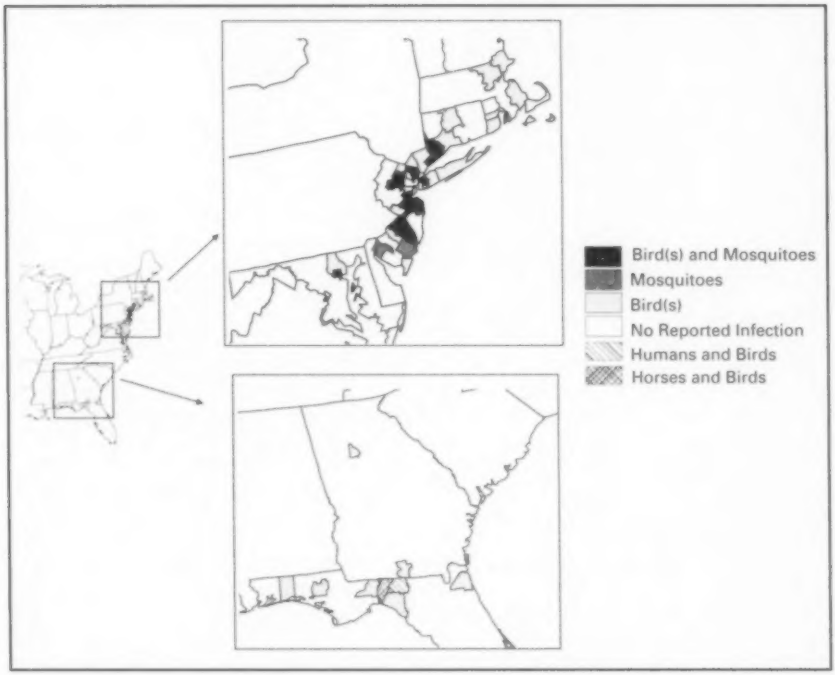
The first human infection in 2001 was identified in a 73-year-old man from Madison County, Florida, with illness onset on approximately July 15. He remains hospitalized with encephalitis. Equine surveillance identified three horses with neurologic disease attributed to WNV infection in Jefferson County, Florida, with illness onsets beginning on June 24. Avian mortality surveillance identified 142 WNV-infected birds from the District of Columbia (one bird) and 34 counties in nine states (Connecticut [four], Florida [21], Georgia [two], Maryland [51], Massachusetts [six], New Jersey [37], New York [16], Rhode Island [three], and Virginia [one]) (Figure 1). Crows accounted for 126 (89%) of the reported birds. In New York City, one live hatch-year house sparrow had antibody to WNV. One sentinel chicken from Duval County, Florida, seroconverted to WNV in a serum specimen drawn on July 10.

WNV also was detected in 38 mosquito pools collected in 10 counties in four states, representing at least nine species, including a pool of six *Culex salinarius* collected in Baltimore, Maryland, on July 11, a mixed pool of *Cx. pipiens/Cx. restuans* collected in Queens, New York, on July 3, a pool of *Ochlerotatus canadensis* collected on July 5 and a pool of *Cx. pipiens* collected on July 16 in Fairfield County, Connecticut, and 34 pools collected in seven New Jersey counties as early as May 31. The New Jersey mosquito pools included *Cx. pipiens* (17 pools), *Cx. restuans* (nine), *Culiseta melanura* (three), unidentified *Aedes/Oc.* species (two), *Ae. vexans* (one), *Oc. canadensis* (one), and *Oc. triseriatus* (one).

Reported by: ArboNET surveillance group in local and state health depts. National Wildlife Health Center, US Geologic Survey, Madison, Wisconsin. National Veterinary Svcs Laboratories, Veterinary Svcs, Animal and Plant Health Inspection Svc, US Dept of Agriculture, Ames, Iowa. Walter Reed Army Institute of Research, District of Columbia. US Air Force, Frederick, Maryland. Arbovirus Diseases Br, Div of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, CDC.

West Nile Virus Activity — Continued

FIGURE 1. Location of human and animal infection with West Nile virus — Eastern United States, 2001



Editorial Note: The findings in this report demonstrate multifocal epizootic WNV activity across the eastern United States, including new areas in the southeast. In 2000, avian mortality surveillance indicated northward spread of epizootic activity from the New York City metropolitan area in late spring and early summer, and southward spread as far as North Carolina in late summer and early fall (*1*), a finding consistent with viral spread by migrating birds (*2*). The detection of WNV in Florida and southern Georgia in 2001, extends substantially the known distribution of this virus. Although first detected in these areas in 2001, WNV may have been introduced into these states earlier, but epizootic viral activity remained below the detection threshold of surveillance.

In 2000, avian mortality surveillance identified 4305 WNV-infected birds, 77 of which were identified by August 1 (*1,3*). The finding of 142 WNV-positive birds as of July 25, 2001, is twice the 2000 surveillance figures, and the geographic distribution of these birds differs between the 2 years. All of the birds identified in the early summer of 2000 were from four states (Connecticut, Massachusetts, New Jersey, and New York), compared with 44% of those identified as of July 25, 2001.

West Nile Virus Activity — Continued

Illness onset on approximately July 15 in the patient from Florida was the earliest of any person reported since the 1999 recognition of WNV in the United States. The extensive epizootic WNV activity and continued geographic expansion of the virus highlight the need for widespread implementation and intensification of surveillance, prevention, and control measures to minimize the risk for human and equine disease. Prevention activities have included the development and maintenance of long-term sustained mosquito-control programs using integrated pest management strategies and public education programs, emphasizing residential mosquito larval control and personal prevention measures to reduce mosquito exposure (*4*).

WNV detection in *Cx. salinarius* and *Ae. vexans* is of particular concern because these species more readily feed on mammals (including humans) than do *Cx. pipiens, Cx. restuans,* or *Cs. melanura,* which have a strong feeding preference for birds (*5*). However, mosquito-control programs in urban areas should continue to emphasize reduction of *Cx. pipiens* populations in the north and *Cx. quinquefasciatus* populations in the south. Although the role of these species in the direct transmission of WNV to humans is unclear, their role in the amplification of this virus and the closely related St. Louis encephalitis (SLE) virus in urban ecosystems is well established (*6,7*). The occurrence of WNV in Florida raises the possibility of transmission of this virus by other mosquito species such as *Cx. nigripalpus,* a primary vector of SLE virus in that state (*8*), and the possibility of a longer transmission season than is typical in regions with a more temperate climate.

The U.S. Geological Survey, CDC, and other federal, state, and local government agencies have collaborated to establish World-Wide Web-based maps to track the spread of WNV. These maps are available at http://cindi.usgs.gov/hazard/event/west_nile/west_nile.html. Additional information also is available from sites maintained by local and state health agencies. A partial listing of these sites is available at http://www.cdc.gov/ncidod/dvbid/westnile/city_states.htm.

References

1. Marfin AA, Petersen LR, Eidson M, et al. Widespread West Nile virus activity, eastern United States, 2000. Emerg Infect Dis 2001;7:730–5.
2. Rappole JH, Derrickson SR, Hubálek Z. Migratory birds and spread of West Nile virus in the Western Hemisphere. Emerg Infect Dis 2000;6:319–28.
3. CDC. Update: West Nile virus activity—Northeastern United States, January–August 7, 2000. MMWR 2000;49:714–7.
4. CDC. Epidemic/epizootic West Nile virus in the United States: revised guidelines for surveillance, prevention, and control, 2001. Available at http://www.cdc.gov/ncidod/dvbid/westnile/resources/wnv-guidelines-apr-2001.pdf. Accessed July 25, 2001.
5. CDC. Guidelines for arbovirus surveillance in the United States. Fort Collins, Colorado: US Department of Health and Human Services, Public Health Service, CDC, 1993. Available at http://www.cdc.gov/ncidod/dvbid/arbor/arboguid.htm. Accessed July 25, 2001.
6. Nasci RN, White DJ, Stirling H, et al. West Nile virus isolates from mosquitoes in New York and New Jersey, 1999. Emerg Infect Dis 2001;7:626–30.
7. Savage HM, Ceianu C, Nicolescu G, et al. Entomologic and avian investigations of an epidemic of West Nile fever in Romania in 1996, with serologic and molecular characterization of a virus isolate from mosquitoes. Am J Trop Med Hyg 1999;61:600–11.
8. Day JF. Predicting St. Louis encephalitis virus epidemics: lessons from recent, and not so recent, outbreaks. Annu Rev Entomol 2001;46:111–38.

Global Progress Toward Laboratory Containment of Wild Polioviruses, June 2001

When the World Health Assembly resolved to eradicate poliomyelitis in 1988, the estimated number of polio cases was 350,000; in 2000, approximately 3000 cases were reported (*1*). Two World Health Organization (WHO) regions (the Americas and Western Pacific) have been certified as polio-free, and a third (European Region) has been free of indigenous wild poliovirus transmission for nearly 3 years (3 years are required for WHO certification). As interruption of wild poliovirus circulation approaches, public health agencies are increasing efforts to minimize the risk for reintroduction of wild polioviruses from laboratory sources. This report describes the global plan for containing laboratory wild polioviruses and summarizes the steps being taken toward implementation.

Once wild poliovirus transmission ceases and laboratories are the only source of wild poliovirus, an increase in precautions will be needed to minimize the risk for reintroducing wild polioviruses from stored sources and for ensuring the safe handling and disposal of these materials, which include wild poliovirus infectious stocks, specimens from polio patients, and products of research or potentially infectious materials (i.e., throat, fecal, or environmental [water and sewage] specimens collected for any purpose at a time and in a geographic location where polio was endemic). Virology laboratories are the most likely sources of infectious materials, but other biomedical laboratories such as bacteriology, parasitology, gastroenterology, nutrition, pathology, and environmental also may store infectious materials.

The *WHO Global Action Plan for Laboratory Containment of Wild Polioviruses* (*2*), developed in collaboration with scientists, ministries of health, and vaccine manufacturers, was endorsed by a 1999 World Health Assembly resolution. The Global Certification Commission stated that a precondition of certification is adequate containment of wild polioviruses (*3*), and the plan outlines three implementation phases: preglobal eradication, postglobal eradication, and post-OPV (oral poliovirus vaccine) immunization.

During the preglobal eradication phase, countries in which wild poliovirus circulation has been interrupted appoint a national task force or coordinator to develop and oversee a national plan. The first step in the plan is to alert biomedical laboratories to the impending eradication of polio, encourage them to dispose appropriately of unneeded wild poliovirus or potentially infectious materials, and establish a national inventory of laboratories that retain such materials. The inventory will provide a list of laboratories to be informed of eradication progress and containment developments and to be notified when eradication occurs and implementation of additional biosafety requirements takes effect.

Many countries/territories are surveying and identifying laboratories for their capacity to store infectious materials (Table 1). Laboratories that do not have the capacity to store infectious materials or routinely do not keep specimens for long periods confirm their inability to serve as a storage facility and are eliminated as a site for wild poliovirus materials. Laboratories identified as having the capacity to store infectious materials are followed up to determine the materials they hold in storage.

The postglobal eradication phase begins soon after detection of the last wild poliovirus in the world. At that time, laboratories storing and handling infectious or potentially infectious materials prepare for certification by implementing biosafety conditions appropriate for the levels of risk presented by the materials under study and laboratory procedures in use. A further increase in biosafety requirements is anticipated when a

TABLE 1. Number and percentage of countries/territories with national task forces, national plans, initiated plans, identified biomedical laboratories, biomedical laboratories that handle infectious or potentially infectious material, and have submitted inventories, by World Health Organization (WHO) region, June 2001

WHO region	No. countries/ territories with task force or coordinator	Region total	(%)	No. countries/ territories with plan	Region total	(%)	No. countries/ territories that have initiated plan*	Region total	(%)	No. laboratories identified for survey	No. laboratories with infectious or potentially infectious materials	No. countries/ territories submitting an inventory of laboratories with infectious or potentially infectious materials	Region total	(%)
African	0	48	—	0	48	—	0	48	—	0	0	0	48	—
Americas	2	47	(4%)	2	47	(4%)	2	47	(4%)	16,781	21	0	47	—
Eastern Mediterranean	17	24	(71%)	17	24	(71%)	7	24	(29%)	1,499	10	2	24	(8%)
European	48	51	(98%)	45	51	(76%)	36	51	(53%)	36,089	254	0	51	—
South-East Asian	7	10	(70%)	7	10	(70%)	1	10	(10%)	63	0	0	10	—
Western Pacific	36	36	(100%)	36	36	(100%)	36	36	(100%)	11,620	98	9	36	(25%)
Total	**110**	**216**	**(51%)**	**107**	**216**	**(50%)**	**82**	**216**	**(38%)**	**66,052**	**383**	**11**	**216**	**(5%)**

* Have initiated a survey of laboratories to identify those storing wild polioviruses and infectious or potentially infectious materials.

Containment of Wild Polioviruses — Continued

global decision is made on OPV cessation. WHO is working with manufacturers of inactive polio vaccine (IPV) to develop a plan for containing poliovirus strains used in manufacturing IPV and to formulate containment guidelines designed to minimize risk during the production of IPV.

The risk for accidental reintroduction of wild poliovirus into a community from a laboratory is possible if four conditions exist: 1) the presence of wild poliovirus infectious materials in a laboratory; 2) an event (e.g., break in standard procedure) that exposes workers to infectious materials containing poliovirus; 3) susceptible workers who replicate and shed the virus in their stool; and 4) susceptible persons in the community who are directly or indirectly exposed to an infected worker. Implementation of the plan cannot ensure absolute containment; however, it will minimize the likelihood of a situation in which the first three conditions occur. The fourth condition is linked to posteradication immunization policy decisions.

Progress is being made in implementing the first phase of laboratory containment (Table 1); 110 (51%) of 216 countries/territories have appointed a national task force and have created a plan. Eleven countries have submitted completed national inventories, and approximately 400 laboratories with wild poliovirus materials have been identified. In the Americas, laboratory containment activities are under way. Canada is in the final stages of preparing its national inventory and the United States is in the initial stage of its laboratory survey. In the Western Pacific, all member states have begun implementation and nine of 36 have finished their national inventory. Laboratory containment activities have increased substantially in the European Region as it prepares for certification; 48 of 51 member states have appointed a task force and 36 of these have started contacting laboratories. Although polio is still endemic in the South-East Asian, Eastern Mediterranean, and African regions, many polio-free countries in these regions have begun preparations for laboratory containment.

Reported by: Vaccines and Biologicals Dept, World Health Organization, Geneva, Switzerland. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

Editorial Note: Appropriate laboratory containment of wild poliovirus is critical to polio eradication. Progress toward implementation of the global plan is encouraging; a systematic and well-documented approach has been established to identify laboratories with infectious wild poliovirus or potentially infectious materials, and cooperation from laboratories and governments has been good throughout the world.

Implementing laboratory containment procedures is a complex process. Industrialized countries with well-developed research programs and laboratory infrastructure will require considerable time and effort for implementing survey and inventory activities. Countries with less developed biomedical research programs and laboratory infrastructure generally do not have laboratories that store infectious materials. Such countries can more easily compile a list of laboratories and identify those with infectious wild poliovirus or potentially infectious materials. Technical expertise for assisting countries with their national plans and implementing activities is available from members of the Global Laboratory Network for Polio Eradication, which comprises 124 national (or subnational) laboratories, 16 regional reference laboratories, and seven specialized laboratories.

The link between certification and laboratory containment activities has evolved; laboratory containment procedures were not part of the certification process when the

Containment of Wild Polioviruses — Continued

Americas was certified free of polio in 1994. The Pan American Health Organization is working with member governments to meet the requirements outlined in the global plan. The most progress toward completion of the first phase of the plan has been reported from the Western Pacific Region where laboratory containment activities were an integral part of the certification process. The European Region is integrating containment into the regional certification process.

WHO member states will be responsible for laboratory containment within their respective countries. The containment process will be monitored by national authorities, national committees for polio eradication, and the Regional and Global Certification commissions. Before global certification can occur, as anticipated in 2005, all countries of the world must demonstrate that they have minimized the risk for reintroducing wild poliovirus from their laboratories to a polio-free world.

References

1. World Health Assembly. Polio eradication by the year 2000. Resolutions of the 41st World Health Assembly. Geneva, Switzerland: World Health Organization, 1988 (Resolution 41.28).
2. Department of Vaccines and Biologicals. World Health Organization global action plan for laboratory containment of wild polioviruses. Geneva, Switzerland: World Health Organization, 1999 (Reference WHO/V&B/99.32).
3. Department of Vaccines and Biologicals. Report of the third meeting of the Global Commission for the Certification of the Eradication of Polio, July 9, 1998. Geneva, Switzerland: World Health Organization, 1999 (Reference WHO/EPI/GEN/981.17).

Heat-Related Deaths — Los Angeles County, California, 1999–2000, and United States, 1979–1998

Heat-related deaths typically occur during summer months. Many of these deaths are preventable. This report describes four cases of heat-related deaths in Los Angeles County, California, during 1999–2000, compares age-, sex-, and race-specific rates in Los Angeles County and the United States during 1979–1998, and summarizes trends in the United States during 1979–1998. Relatives, neighbors, and caretakers of persons at risk for heat-related death should frequently evaluate heat-related hazards, recognize symptoms of heat-related morbidity, and take appropriate preventive action.

Case Reports

Case 1. In June 1999, a 4-month-old boy was found dead in his parents' car. The child had been left in the car with windows closed for 6 hours. Death was attributed to hyperthermia. The temperature inside the car was 118 F (47.8 C), and the outside temperature was 96.0 F (35.6 C).

Case 2. In July 1999, an 81-year-old woman with a medical history of dementia and heart disease was found dead on the roof of the residential-care center where she lived. She had last been seen alive 64 hours earlier and had been reported missing for 24 hours before she was found. The decedent wore a "wanderer" bracelet that sounded an alarm when she exited through the front door of the center. The roof door was not equipped with an alarm but was usually kept locked. Death was attributed to hyperthermia. The ambient temperature on the roof was 96.0 F (35.6 C) at the time the decedent was found.

Case 3. In July 2000, a 46-year-old man was found confused and rolling on the pavement of a parking lot near his residence. When an ambulance arrived, he was unconscious and had had seizures. The local ambient temperature was 109.0 F (42.8 C) at the

Heat-Related Deaths — Continued

time he was found. At the emergency department, his temperature was 107.0 F (41.7 C). He died 2 days later in a hospital. Laboratory tests showed a blood alcohol level of 93 mg/dL (the legal blood alcohol limit in California is 80 mg/dL) and a positive screen for cocaine. Death was attributed to hyperthermia.

Case 4. In August 2000, a 65-year-old woman was found unresponsive in the backyard of her residence. She was admitted to a hospital where she died 2 days later. Her body temperature on admission was 108.0 F (42.2 C). The decedent had a medical history of insulin-dependent diabetes, hypertension, and heart disease. The underlying cause of death was hyperthermia.

U.S. Trends and Summary of Rates in Los Angeles County

During 1979–1998 (the most recent years for which national data are available), 7421 deaths in the United States were heat-related* with a median of 274 deaths per year (range: 148–1700), and a median heat-related death rate of 0.1 per 100,000 population (range: 0.1–0.8). Heat-related death rates appear to be stable over time in all age groups with the highest mortality among persons aged ≥65 years (Figure 1).

During 1979–1998, the age-adjusted† heat-related death rate in Los Angeles County was 44% lower than that in the general U.S. population (0.90 per 100,000 population versus 0.16). Los Angeles residents aged ≥65 years were more likely than residents aged <65 years to die from exposure to excessive heat, but the rate ratio was smaller than in the general U.S. population (2.4 versus 7.4). Men in Los Angeles were more likely than women to die from exposure to excessive heat, and the rate ratio of 2.0 was the same as in the general U.S. population. Although blacks in Los Angeles County were more likely than whites to die from exposure to excessive heat, the rate ratio was smaller than in the general U.S. population (1.4 versus 4.9). Persons of other (nonblack and nonwhite§) races in Los Angeles County were less likely than whites to die from exposure to excessive heat, but the rate ratio was smaller than in the general U.S. population (0.5 versus 0.8).

Reported by: L Sathyavagiswaran, MD, Dept of the Coroner, Los Angeles County; JE Fielding, MD, D Dassy, MD, Los Angeles County Dept of Health Svcs. Health Studies Br, Div of Environmental Hazards and Health Effects, National Center for Environmental Health; and EIS officers, CDC.

Editorial Note: These case reports illustrate some of the risks for hyperthermia. The primary risk factors include age (i.e., increasing age, except children aged <5 years who are at higher risk than older children), behavior (e.g., low fluid intake, excessive exercise, prolonged stay in nonair-conditioned places, and alcohol and/or drug use) (*1*), chronic disease (e.g., cardiac or mental illness) (*2,3*), prescription drugs (e.g., psychotropic medication) (*3*), living conditions (e.g., low income, residence in urban areas, no access to air-conditioning, and social isolation) (*1*), and prolonged outdoor activities (e.g., agricultural work and recreational running).

---

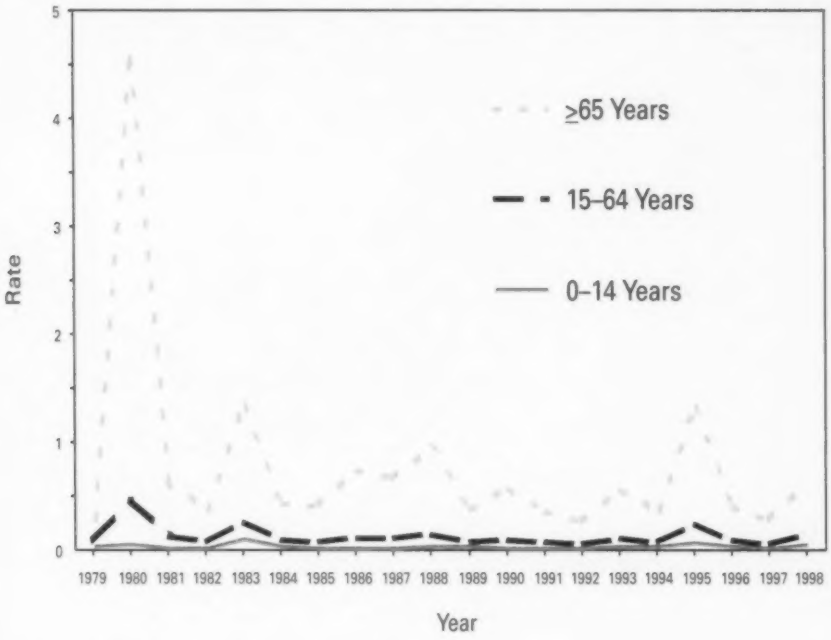
*Underlying cause of death attributed to "excessive heat exposure," classified according to the *International Classification of Diseases, Ninth Revision* (ICD-9), code E900.0, "due to weather conditions" (deaths); code E900.1, "of manmade origin" (deaths); or code E900.9, "of unspecified origin" (deaths). Data were obtained from the Compressed Mortality File of CDC's National Center for Health Statistics, which contains information from death certificates filed in the 50 states and the District of Columbia.

† Rates were age-adjusted to the 2000 U.S. standard population.

§ Race in the Compressed Mortality File was categorized as white, black, and other.

Heat-Related Deaths — Continued

FIGURE 1. Rate* of heat-related deaths, by age group — United States, 1979–1998



* Per 100,000 population.

Heat-related illness can begin as sunburn and fatigue and progress to heat cramps, heat exhaustion, and heatstroke. The two most serious types of heat-related illness are heat exhaustion (heavy sweating, paleness, muscle cramps, tiredness or weakness, dizziness or headache, nausea or vomiting, and faintness) and heatstroke (oral temperature of ≥103.0 F [≥39.4 C]; rapid, strong pulse; red, hot, and dry or sweaty skin; throbbing headache or dizziness; nausea; confusion; and unconsciousness). Untreated heat exhaustion can progress to heatstroke (*4*), a medical emergency that can develop in ≤24 hours (*5*). Even when treated, the death rate for heatstroke may be as high as 33% (*6*). Permanent neurologic damage occurs in up to 17% of survivors (*7*), and its likelihood increases with longer duration of heatstroke (*4*).

Spending time in an air-conditioned area is the most important factor in preventing heat-related deaths (*2*). During the 1999 heat wave in Cincinnati, Ohio, three of 18 heat-related deaths occurred in assisted-care facilities for persons with mental illness that did not have air-conditioning (*8*). The use of fans does not appear to be protective. If exposure to heat cannot be avoided, prevention measures should include reducing, eliminating, or rescheduling strenuous activities; frequently drinking water or nonalcoholic fluids; frequently taking showers; wearing light-weight and light-colored clothing; and avoiding direct sunshine.

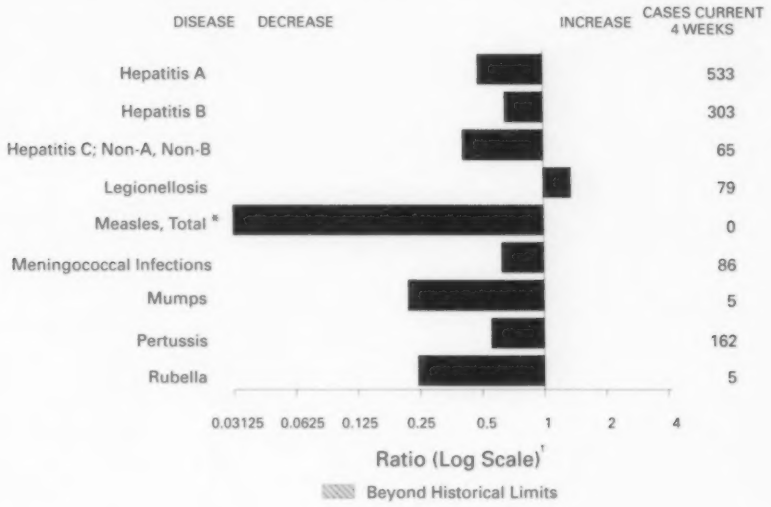
Heat-Related Deaths — Continued

Because heat-related morbidity and mortality could increase with more periods of extreme heat in future summers (*9*), many cities have developed heat emergency response plans. These response plans use information on risk factors and meteorologic information to implement prevention strategies that reduce morbidity and mortality from excessive heat (*1*). A heat response plan also should address rolling energy blackouts in areas that use air-conditioning to mitigate many of the factors that increase the risk for heat-related morbidity and mortality. To defray energy costs, support of low-income populations may be necessary to allow the use of air-conditioning during summer months.

References

1. McGeehin MA, Mirabelli M. The potential impacts of climate variability and change on temperature-related morbidity and mortality in the United States. Environ Health Perspec 2001;109:185–90.
2. Semenza JC, Rubin CH, Falter KH, et al. Heat-related deaths during the 1995 heat wave in Chicago. N Engl J Med 1996;335:84–90.
3. Batscha CL. Heat stroke: keeping your clients cool in the summer. J Psychosoc Nurs Ment Health Serv 1997;35:12–7.
4. Knochel JP. Environmental heat illness: an eclectic review. Arch Intern Med 1974;133: 841–64.
5. Jones TS, Liang AP, Kilbourne EM, et al. Morbidity and mortality associated with the July 1980 heat wave in St. Louis and Kansas City, Mo. JAMA 1982;247:3327–31.
6. Vicario SJ, Okabajue R, Haltom T. Rapid cooling in classic heatstroke: effect on mortality rates. Am J Emerg Med 1986;4:394–8.
7. Hart GR, Anderson RJ, Crumpler CP, Shulkin A, Reed G, Knochel JP. Epidemic classical heat stroke: clinical characteristics and course of 28 patients. Medicine 1982;61:189–97.
8. Kaiser R, Rubin CH, Henderson A, et al. Heat-related death and mental illness during the 1999 Cincinnati heat wave. Am J Forensic Med Pathol(in press).
9. Gaffen DJ. Increased summertime heat stress in the US. Nature 1998;396:529–30.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending July 21, 2001, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 29 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending July 21, 2001 (29th Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	38	Psittacosis*	7
Cholera	4	Q fever*	11
Cyclosporiasis*	63	Rabies, human	1
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	217
Ehrlichiosis: human granulocytic (HGE)*	68	Rubella, congenital syndrome	-
human monocytic (HME)*	28	Streptococcal disease, invasive, group A	2,182
Encephalitis: California serogroup viral*	5	Streptococcal toxic-shock syndrome*	33
eastern equine*	1	Syphilis, congenital§	84
St. Louis*	-	Tetanus	13
western equine*	-	Toxic-shock syndrome	66
Hansen disease (leprosy)*	39	Trichinosis	11
Hantavirus pulmonary syndrome*†	4	Tularemia*	47
Hemolytic uremic syndrome, postdiarrheal*	52	Typhoid fever	139
HIV infection, pediatric*†	98	Yellow fever	-
Plague	2		

-: No reported cases.
*Not notifiable in all states.
† Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update June 26, 2001.
§ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 21, 2001, and July 22, 2000 (29th Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	19,145	21,713	362,229	379,078	926	902	958	1,686	765	1,564
NEW ENGLAND	746	1,279	12,290	12,643	38	56	111	172	76	183
Maine	20	20	662	770	4	9	14	9	14	14
N.H.	17	21	698	575	2	6	14	14	11	18
Vt.	10	17	330	298	13	14	4	20	2	22
Mass.	411	837	5,573	5,344	12	17	58	80	28	72
R.I.	53	48	1,552	1,408	3	2	6	8	4	10
Conn.	235	336	3,475	4,248	4	8	15	41	17	47
MID. ATLANTIC	3,974	5,227	41,389	36,436	108	164	82	188	59	136
Upstate N.Y.	322	539	7,355	640	49	40	61	115	33	38
N.Y. City	1,996	2,852	15,718	15,193	51	91	4	14	7	8
N.J.	960	1,024	5,521	7,138	4	7	17	59	19	56
Pa.	696	812	12,795	13,465	4	26	N	N	-	36
E.N. CENTRAL	1,408	2,068	52,783	64,574	296	212	220	349	161	279
Ohio	237	290	7,727	17,278	62	24	62	56	47	72
Ind.	165	188	8,037	7,118	32	12	37	43	21	43
Ill.	665	1,191	14,031	18,527	1	34	47	96	41	69
Mich.	261	296	16,524	12,748	72	35	26	51	27	42
Wis.	80	103	6,464	8,903	129	107	48	103	25	53
W.N. CENTRAL	454	487	18,357	21,202	91	76	123	220	140	267
Minn.	85	86	3,412	4,352	32	11	36	47	63	80
Iowa	47	52	1,858	2,761	28	25	28	44	24	57
Mo.	218	226	6,616	7,279	10	12	22	58	29	56
N. Dak.	1	2	520	493	3	5	1	7	10	14
S. Dak.	18	4	957	996	5	8	9	14	8	19
Nebr.	39	31	1,696	2,052	13	12	16	35	-	31
Kans.	46	86	3,298	3,269	-	3	11	15	6	10
S. ATLANTIC	6,167	5,749	66,953	70,449	161	134	95	119	48	142
Del.	116	94	1,606	1,570	1	4	1	1	3	-
Md.	751	690	6,670	7,468	27	7	7	13	1	1
D.C.	465	389	1,663	1,771	9	5	-	-	U	U
Va.	501	380	9,657	8,997	10	4	24	24	18	29
W. Va.	49	31	1,275	1,185	1	3	3	8	1	5
N.C.	402	312	8,914	12,103	18	15	26	22	13	37
S.C.	350	455	6,208	5,105	-	-	2	8	3	9
Ga.	757	605	12,438	14,459	56	63	14	15	2	26
Fla.	2,776	2,793	18,522	17,791	39	33	18	28	7	35
E.S. CENTRAL	977	1,051	26,994	27,468	24	27	44	61	41	55
Ky.	201	127	4,872	4,418	3	3	15	21	21	19
Tenn.	293	438	8,022	7,946	5	6	20	23	18	28
Ala.	224	255	7,578	8,228	9	10	8	5	-	4
Miss.	259	231	6,522	6,876	7	8	1	12	2	4
W.S. CENTRAL	2,058	2,333	56,698	57,283	18	47	35	150	52	183
Ark.	104	111	4,094	3,587	3	1	4	36	-	30
La.	472	318	9,388	10,525	7	10	2	10	23	27
Okla.	107	184	5,815	4,732	6	4	12	9	14	7
Tex.	1,375	1,720	37,401	38,439	2	32	17	95	15	119
MOUNTAIN	714	806	19,639	22,173	62	42	115	179	77	136
Mont.	12	9	1,015	825	5	8	6	20	-	-
Idaho	15	13	909	1,031	7	3	15	23	-	18
Wyo.	1	7	454	410	1	5	5	10	1	6
Colo.	140	200	2,908	6,662	19	12	50	67	44	50
N. Mex.	56	87	3,066	2,732	12	2	8	6	6	7
Ariz.	295	224	7,769	7,070	4	2	15	28	9	22
Utah	63	81	906	1,339	12	8	10	21	16	27
Nev.	132	185	2,612	2,104	2	2	6	4	1	6
PACIFIC	2,647	2,713	67,126	66,850	128	144	133	248	111	183
Wash.	290	275	7,339	7,054	N	U	32	89	31	104
Oreg.	112	88	2,159	3,868	14	9	22	41	17	46
Calif.	2,204	2,255	54,101	52,618	111	135	69	101	60	25
Alaska	13	12	1,492	1,354	-	-	2	9	-	1
Hawaii	28	83	2,035	1,956	3	-	8	8	3	7
Guam	9	13	-	263	-	-	N	N	U	U
P.R.	580	706	1,611	U	-	-	-	5	U	U
V.I.	2	24	53	-	-	-	-	-	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	69	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update June 26, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending July 21, 2001, and July 22, 2000 (29th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	165,190	189,589	1,190	1,864	425	446	223	2,580	6,811
NEW ENGLAND	3,387	3,566	14	15	20	25	29	728	1,709
Maine	73	46	-	1	1	2	-	-	-
N.H.	87	59	-	-	5	2	1	69	36
Vt.	41	32	6	3	4	2	1	3	12
Mass.	1,707	1,429	8	8	5	11	15	150	706
R.I.	399	341	-	3	1	3	1	109	78
Conn.	1,080	1,659	-	-	4	5	11	397	877
MID. ATLANTIC	20,055	20,566	48	402	45	109	32	1,135	3,853
Upstate N.Y.	4,396	3,752	34	17	28	32	14	891	1,106
N.Y. City	6,603	6,377	-	-	6	16	6	1	144
N.J.	2,951	4,155	-	360	5	9	7	85	1,727
Pa.	6,105	6,282	14	25	6	52	5	158	876
E.N. CENTRAL	28,066	37,999	105	144	116	118	26	145	491
Ohio	4,537	10,145	7	4	61	41	7	46	26
Ind.	3,295	3,268	1	-	12	22	4	3	10
Ill.	8,608	11,349	10	15	-	15	-	-	27
Mich.	9,481	9,447	87	125	29	21	13	-	13
Wis.	2,145	3,790	-	-	14	19	2	96	415
W.N. CENTRAL	7,630	9,309	397	329	34	28	6	108	83
Minn.	1,091	1,739	3	5	7	1	-	69	42
Iowa	428	589	-	1	6	6	-	18	4
Mo.	3,962	4,585	387	315	12	14	3	15	22
N. Dak.	16	39	-	-	1	-	-	-	-
S. Dak.	144	154	-	-	3	1	-	-	-
Nebr.	556	774	3	3	4	2	1	2	2
Kans.	1,433	1,429	4	5	1	4	2	4	13
S. ATLANTIC	41,409	49,208	59	54	94	80	37	365	551
Del.	907	903	-	2	2	5	-	22	103
Md.	3,712	4,994	10	6	22	25	4	224	338
D.C.	1,468	1,275	-	2	7	-	-	7	2
Va.	5,253	5,541	-	3	11	13	6	72	63
W. Va.	341	365	6	12	N	N	4	8	17
N.C.	7,980	9,829	10	13	5	8	2	16	20
S.C.	4,499	4,876	4	1	4	2	3	2	2
Ga.	6,762	9,099	-	2	6	4	8	-	-
Fla.	10,487	12,326	29	13	37	23	10	14	6
E.S. CENTRAL	17,389	19,653	124	267	34	15	11	17	22
Ky.	1,878	1,879	4	18	8	7	4	7	5
Tenn.	5,347	6,215	41	59	16	5	3	6	13
Ala.	5,921	6,509	2	7	8	2	4	4	2
Miss.	4,243	5,050	77	183	2	1	-	-	2
W.S. CENTRAL	27,325	29,905	161	503	5	18	5	7	42
Ark.	2,521	1,959	3	4	-	-	1	-	3
La.	6,539	7,440	74	268	2	7	-	1	3
Okla.	2,609	2,038	3	4	3	1	1	-	-
Tex.	15,656	18,468	81	227	-	10	3	6	36
MOUNTAIN	5,529	5,754	201	39	34	22	23	8	4
Mont.	53	26	1	2	-	1	-	-	-
Idaho	39	50	1	3	2	4	1	3	1
Wyo.	32	30	159	2	3	-	1	3	2
Colo.	1,748	1,763	13	6	10	6	3	1	-
N. Mex.	487	581	10	11	2	1	6	-	-
Ariz.	2,152	2,375	9	11	11	5	6	-	-
Utah	79	140	2	-	4	5	1	-	-
Nev.	939	789	6	4	2	-	5	1	1
PACIFIC	14,400	13,629	81	111	43	31	54	67	56
Wash.	1,607	1,217	16	16	6	11	3	2	3
Oreg.	307	503	9	21	N	N	1	5	4
Calif.	11,942	11,469	56	72	33	20	49	58	48
Alaska	213	182	-	-	-	-	-	2	1
Hawaii	331	258	-	2	4	-	1	N	N
Guam	-	26	-	2	-	-	-	-	-
P.R.	438	293	1	1	2	-	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	7	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending July 21, 2001, and July 22, 2000 (29th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	529	694	3,194	3,688	15,621	18,150	12,839	16,188
NEW ENGLAND	34	34	328	403	1,209	1,128	1,032	1,179
Maine	3	4	40	80	111	80	93	61
N.H.	2	1	7	8	106	72	108	79
Vt.	-	2	37	37	39	65	38	61
Mass.	11	13	116	129	679	669	460	659
R.I.	3	5	29	18	66	45	85	84
Conn.	15	9	99	131	208	197	248	235
MID. ATLANTIC	97	156	509	655	1,643	2,575	1,974	2,657
Upstate N.Y.	28	31	381	400	578	582	479	675
N.Y. City	44	84	12	6	460	664	661	679
N.J.	19	21	95	88	419	635	413	501
Pa.	6	20	21	161	186	694	421	802
E.N. CENTRAL	56	83	44	54	2,270	2,524	1,835	1,600
Ohio	14	12	16	13	694	585	544	583
Ind.	12	4	1	-	249	285	241	315
Ill.	1	43	4	9	575	816	429	1
Mich.	19	17	17	23	396	476	397	510
Wis.	10	7	6	9	356	362	224	191
W.N. CENTRAL	23	36	188	336	945	1,185	1,072	1,346
Minn.	6	13	20	50	259	262	355	361
Iowa	3	1	43	47	158	174	163	183
Mo.	8	9	16	23	252	375	357	446
N. Dak.	-	2	24	83	14	27	38	49
S. Dak.	-	-	21	64	72	46	63	58
Nebr.	2	5	4	-	69	109	-	88
Kans.	4	6	60	69	121	192	96	161
S. ATLANTIC	156	152	1,181	1,283	3,885	3,272	2,340	2,816
Del.	1	3	18	20	44	58	43	68
Md.	66	50	153	245	409	398	389	382
D.C.	10	12	-	-	39	32	U	U
Va.	30	31	236	332	747	456	495	463
W. Va.	1	2	76	69	54	74	71	78
N.C.	7	11	324	313	549	432	459	488
S.C.	4	1	78	76	376	304	345	268
Ga.	8	4	174	157	564	522	351	822
Fla.	29	38	122	71	1,103	996	187	247
E.S. CENTRAL	15	22	110	105	935	952	714	800
Ky.	5	6	11	15	171	188	110	141
Tenn.	7	5	71	56	264	218	302	367
Ala.	3	10	28	34	296	257	235	246
Miss.	-	1	-	-	204	289	67	46
W.S. CENTRAL	6	42	504	529	1,226	2,266	1,079	1,398
Ark.	3	1	19	-	287	281	92	245
La.	1	7	-	1	249	395	344	309
Okla.	1	4	43	36	144	176	132	141
Tex.	1	30	442	492	546	1,414	511	703
MOUNTAIN	29	29	127	143	1,098	1,387	755	1,323
Mont.	2	1	20	39	40	61	-	-
Idaho	3	2	2	1	72	76	4	70
Wyo.	-	-	20	37	34	40	22	32
Colo.	15	14	-	-	300	414	276	393
N. Mex.	1	-	6	13	128	122	106	121
Ariz.	3	5	76	50	329	323	216	347
Utah	3	3	2	2	123	210	108	217
Nev.	2	4	1	1	72	141	23	143
PACIFIC	113	140	203	180	2,410	2,861	2,038	3,069
Wash.	4	13	-	-	231	236	358	349
Oreg.	5	23	-	4	120	174	167	223
Calif.	96	96	166	152	1,839	2,308	1,332	2,357
Alaska	1	-	37	24	24	31	2	23
Hawaii	7	8	-	-	196	112	179	117
Guam	-	-	-	-	-	17	U	U
P.R.	3	4	61	42	310	314	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	7	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending July 21, 2001, and July 22, 2000 (29th Week)

Reporting Area	Shigellosis*				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS					
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	7,538	11,190	3,766	6,191	2,986	3,370	6,346	7,543
NEW ENGLAND	120	205	106	193	28	48	227	215
Maine	6	6	1	-	-	1	7	8
N.H.	2	4	2	7	1	1	11	8
Vt.	3	2	2	-	2	-	2	3
Mass.	79	145	63	131	16	32	122	124
R.I.	8	12	14	19	3	3	21	23
Conn.	22	36	24	36	6	11	64	49
MID. ATLANTIC	606	1,565	498	977	265	162	1,211	1,220
Upstate N.Y.	329	444	64	161	19	6	167	147
N.Y. City	182	686	236	437	139	69	629	650
N.J.	40	293	133	247	54	36	276	295
Pa.	55	142	65	132	53	51	139	128
E.N. CENTRAL	1,457	2,366	654	700	506	711	668	720
Ohio	852	157	357	131	46	44	111	154
Ind.	128	884	23	107	102	225	49	74
Ill.	209	657	143	2	122	246	343	325
Mich.	155	469	116	424	219	163	130	117
Wis.	113	199	15	36	17	33	35	50
W.N. CENTRAL	813	1,117	685	946	35	43	231	269
Minn.	237	292	282	347	17	6	122	88
Iowa	254	269	215	207	1	10	18	23
Mo.	138	402	111	282	8	22	59	100
N. Dak.	13	4	7	4	-	-	3	2
S. Dak.	87	4	50	3	-	-	8	11
Nebr.	41	39	-	44	1	2	21	11
Kans.	43	107	20	59	8	3	-	34
S. ATLANTIC	1,163	1,369	344	515	1,092	1,108	1,298	1,522
Del.	5	9	4	10	7	5	9	7
Md.	62	79	33	43	126	163	111	144
D.C.	29	22	U	U	21	21	15	11
Va.	116	229	56	186	66	69	126	150
W. Va.	6	3	7	3	-	2	17	19
N.C.	211	68	101	47	250	315	192	216
S.C.	143	66	67	54	149	122	119	150
Ga.	124	126	57	108	169	206	235	318
Fla.	467	767	19	64	304	205	474	507
E.S. CENTRAL	760	522	335	315	346	496	414	507
Ky.	289	158	142	48	26	53	71	58
Tenn.	53	222	60	241	191	303	147	195
Ala.	149	30	113	23	70	67	144	171
Miss.	269	112	20	3	59	73	52	83
W.S. CENTRAL	1,011	1,806	683	528	380	454	668	1,123
Ark.	379	116	155	42	21	60	81	115
La.	108	168	106	97	74	112	-	71
Okla.	21	65	10	23	37	70	75	86
Tex.	503	1,457	412	366	248	212	512	851
MOUNTAIN	466	499	253	340	122	122	228	284
Mont.	1	5	-	-	-	-	-	6
Idaho	21	36	-	23	-	1	7	4
Wyo.	2	2	-	2	-	1	2	1
Colo.	93	88	80	46	23	5	66	41
N. Mex.	64	52	40	34	10	10	11	28
Ariz.	224	199	99	135	78	100	90	121
Utah	28	37	26	43	7	1	16	26
Nev.	33	80	8	57	4	4	36	57
PACIFIC	1,142	1,741	208	1,677	212	226	1,401	1,683
Wash.	97	324	119	291	32	36	124	141
Oreg.	40	104	61	65	4	8	52	50
Calif.	971	1,283	-	1,298	170	181	1,115	1,347
Alaska	4	6	1	3	-	-	26	66
Hawaii	30	24	27	20	6	1	84	79
Guam	-	26	U	U	-	2	-	32
P.R.	6	21	U	U	259	99	54	70
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	4	U	U	U	-	U	19	U

N: Not notifiable. U: Unavailable. -: No reported cases.

*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 21, 2001, and July 22, 2000 (29th Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	795	752	5,021	7,034	3,347	3,809	-	43	-	31	74	58
NEW ENGLAND	43	59	233	203	58	62	-	4	-	1	5	3
Maine	1	1	5	10	5	5	-	-	-	-	-	-
N.H.	-	9	10	17	11	11	-	-	-	-	-	-
Vt.	2	4	6	6	3	6	-	1	-	-	1	3
Mass.	32	29	74	83	3	6	-	2	-	1	3	-
R.I.	2	1	11	7	12	9	-	-	-	-	-	-
Conn.	6	15	127	80	24	25	-	1	-	-	1	-
MID. ATLANTIC	96	141	421	754	447	656	-	2	-	9	11	20
Upstate N.Y.	42	52	148	126	78	68	-	1	-	4	5	9
N.Y. City	25	39	171	271	261	314	-	-	-	-	-	10
N.J.	26	29	70	130	64	110	-	-	-	1	1	-
Pa.	3	21	32	227	44	164	-	1	-	4	5	1
E.N. CENTRAL	107	111	558	903	417	403	-	-	-	10	10	6
Ohio	48	36	136	154	66	69	-	-	-	3	3	2
Ind.	32	12	51	30	24	28	-	-	-	4	4	-
Ill.	10	41	157	389	62	61	-	-	-	3	3	3
Mich.	5	7	175	279	265	226	-	-	-	-	-	1
Wis.	12	15	39	51	-	19	-	-	-	-	-	-
W.N. CENTRAL	38	34	219	482	108	171	-	4	-	-	4	1
Minn.	21	16	16	129	13	20	-	2	-	-	2	1
Iowa	-	-	18	50	14	17	-	-	-	-	-	-
Mo.	11	11	59	213	53	90	-	2	-	-	2	-
N. Dak.	4	2	2	2	-	2	-	-	-	-	-	-
S. Dak.	-	-	1	-	1	-	-	-	-	-	-	-
Nebr.	1	3	27	21	14	26	-	-	-	-	-	-
Kans.	1	2	96	67	13	16	-	-	-	-	-	-
S. ATLANTIC	242	179	1,140	720	725	646	-	3	-	1	4	2
Del.	-	-	-	10	-	9	-	-	-	-	-	-
Md.	57	51	149	89	88	76	-	2	-	1	3	-
D.C.	-	-	27	15	11	19	-	-	-	-	-	-
Va.	18	29	68	85	85	83	-	-	-	-	-	2
W. Va.	8	4	7	46	16	6	-	-	-	-	-	-
N.C.	32	17	85	97	111	142	-	-	-	-	-	-
S.C.	5	7	38	30	16	5	-	-	-	-	-	-
Ga.	61	47	457	116	176	101	-	1	-	-	1	-
Fla.	61	24	309	233	222	205	-	-	-	-	-	-
E.S. CENTRAL	56	33	184	269	225	268	-	2	-	-	2	-
Ky.	2	12	40	32	17	53	-	2	-	-	2	-
Tenn.	28	14	78	95	118	124	-	-	-	-	-	-
Ala.	25	5	58	37	51	27	-	-	-	-	-	-
Miss.	1	2	8	105	39	64	-	-	-	-	-	-
W.S. CENTRAL	29	42	608	1,301	359	586	-	1	-	-	1	-
Ark.	-	-	43	97	56	64	-	-	-	-	-	-
La.	3	12	46	45	28	83	-	-	-	-	-	-
Okla.	26	28	86	158	63	78	-	-	-	-	-	-
Tex.	-	2	433	1,001	212	361	-	1	-	-	1	-
MOUNTAIN	110	76	476	485	335	280	-	-	-	1	1	12
Mont.	-	-	8	3	2	3	-	-	-	-	-	-
Idaho	1	3	48	18	8	4	-	-	-	1	1	-
Wyo.	13	1	21	4	29	-	-	-	-	-	-	-
Colo.	25	16	41	115	70	46	-	-	-	-	-	2
N. Mex.	14	16	18	44	81	89	-	-	-	-	-	-
Ariz.	42	31	250	233	105	99	-	-	-	-	-	-
Utah	6	6	48	33	15	14	-	-	-	-	-	3
Nev.	9	3	42	36	25	25	-	-	-	-	-	7
PACIFIC	74	77	1,182	1,917	673	737	-	27	-	9	36	14
Wash.	1	3	64	167	72	44	-	13	-	2	15	3
Oreg.	16	22	49	124	43	60	-	3	-	-	3	-
Calif.	32	29	1,056	1,604	541	619	-	8	-	4	12	8
Alaska	3	4	12	11	5	6	-	-	-	-	-	1
Hawaii	22	19	1	11	12	8	-	3	-	3	6	2
Guam	-	1	-	1	-	9	U	-	U	-	-	-
P.R.	1	3	56	173	99	156	-	-	-	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	20	U	-	-	-	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*For imported measles, cases include only those resulting from importation from other countries.
† Of 160 cases among children aged <5 years, serotype was reported for 72, and of those, 11 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 21, 2001, and July 22, 2000 (29th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	1,393	1,405	1	109	206	31	2,440	3,168	1	16	95
NEW ENGLAND	79	85	-	-	3	1	256	860	-	-	11
Maine	1	6	-	-	-	-	-	14	-	-	-
N.H.	10	9	-	-	-	-	25	62	-	-	2
Vt.	4	2	-	-	-	1	25	161	-	-	-
Mass.	45	50	-	-	1	-	190	580	-	-	8
R.I.	2	6	-	-	1	-	2	11	-	-	-
Conn.	17	12	-	-	1	-	14	32	-	-	1
MID. ATLANTIC	116	155	-	10	13	1	201	259	-	4	8
Upstate N.Y.	43	41	-	1	5	1	108	138	-	1	1
N.Y. City	29	33	-	6	5	-	33	44	-	2	7
N.J.	34	27	-	-	-	-	8	-	-	1	-
Pa.	10	54	-	3	3	-	52	77	-	-	-
E.N. CENTRAL	169	244	-	12	17	4	276	363	-	3	1
Ohio	58	55	-	1	7	-	168	182	-	-	-
Ind.	27	31	-	1	-	3	27	36	-	1	-
Ill.	20	61	-	8	5	1	30	28	-	2	1
Mich.	33	71	-	2	4	-	27	42	-	-	-
Wis.	31	26	-	-	1	-	24	75	-	-	-
W.N. CENTRAL	101	91	-	5	12	2	121	165	-	2	1
Minn.	15	7	-	2	-	-	31	75	-	-	-
Iowa	21	21	-	-	5	-	16	26	-	1	-
Mo.	37	46	-	-	4	2	55	33	-	-	-
N. Dak.	5	2	-	-	-	-	-	1	-	-	-
S. Dak.	4	5	-	-	-	-	3	3	-	-	-
Nebr.	10	4	-	1	1	-	3	4	-	-	1
Kans.	9	6	-	2	2	-	13	23	-	1	-
S. ATLANTIC	272	201	-	18	29	3	122	239	1	4	50
Del.	2	-	-	-	-	-	-	6	-	-	-
Md.	32	19	-	4	6	-	17	65	1	1	-
D.C.	-	-	-	-	-	-	1	2	-	-	-
Va.	28	34	-	2	5	1	13	33	-	-	-
W. Va.	10	9	-	-	-	-	1	1	-	-	-
N.C.	55	30	-	1	4	1	41	51	-	-	42
S.C.	25	15	-	1	9	1	23	20	-	2	6
Ga.	37	36	-	7	2	-	7	20	-	-	-
Fla.	83	58	-	3	3	-	19	41	-	1	2
E.S. CENTRAL	96	99	-	3	4	2	56	66	-	1	4
Ky.	16	20	-	1	-	-	11	32	-	-	1
Tenn.	43	40	-	-	2	1	24	19	-	1	-
Ala.	29	29	-	-	2	1	18	12	-	-	3
Miss.	8	10	-	2	-	-	3	3	-	-	-
W.S. CENTRAL	167	150	-	8	22	3	200	145	-	-	6
Ark.	12	8	-	1	1	-	7	14	-	-	1
La.	54	36	-	2	4	-	2	9	-	-	1
Okla.	21	21	-	-	-	-	1	9	-	-	-
Tex.	80	86	-	5	17	3	190	113	-	-	4
MOUNTAIN	74	64	-	7	14	10	912	412	-	1	2
Mont.	3	4	-	-	1	3	13	12	-	-	-
Idaho	7	6	-	-	-	-	164	41	-	-	-
Wyo.	6	-	-	1	1	-	1	2	-	-	-
Colo.	25	20	-	1	-	2	162	229	-	1	1
N. Mex.	11	6	-	2	1	2	63	70	-	-	-
Ariz.	11	19	-	1	3	-	460	40	-	-	1
Utah	7	6	-	1	4	3	40	12	-	-	-
Nev.	4	3	-	1	4	-	9	6	-	-	-
PACIFIC	319	316	1	46	92	5	296	659	-	1	12
Wash.	46	33	-	1	3	3	82	202	-	-	7
Oreg.	24	38	N	N	N	2	29	63	-	-	-
Calif.	239	232	1	27	71	-	165	357	-	-	5
Alaska	2	5	-	1	7	-	2	12	-	-	-
Hawaii	8	8	-	17	11	-	18	25	-	1	-
Guam	-	-	U	-	11	U	-	3	U	-	1
P.R.	3	7	-	-	-	-	2	4	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	-	U	-	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending July 21, 2001 (29th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	541	375	96	45	15	10	58
Boston, Mass.	131	78	31	12	5	5	11
Bridgeport, Conn.	34	23	9	2	-	-	3
Cambridge, Mass.	22	14	5	3	-	-	3
Fall River, Mass.	33	25	5	3	-	-	2
Hartford, Conn.	74	50	14	6	3	1	9
Lowell, Mass.	25	18	3	3	1	-	1
Lynn, Mass.	12	10	1	1	-	-	3
New Bedford, Mass.	27	23	1	3	-	-	5
New Haven, Conn.	46	30	8	3	2	3	5
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	5	4	1	-	-	-	1
Springfield, Mass.	47	36	6	3	2	-	6
Waterbury, Conn.	27	23	2	2	-	-	5
Worcester, Mass.	58	41	10	4	2	1	4
MID. ATLANTIC	2,096	1,483	413	125	40	35	107
Albany, N.Y.	54	37	12	1	2	2	5
Allentown, Pa.	16	15	1	-	-	-	1
Buffalo, N.Y.	76	54	15	6	-	1	7
Camden, N.J.	33	20	5	5	2	1	5
Elizabeth, N.J.	16	14	2	-	-	-	-
Erie, Pa.§	44	37	5	1	-	1	5
Jersey City, N.J.	45	30	10	2	2	1	-
New York City, N.Y.	1,116	766	239	72	20	19	50
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	12	8	2	-	1	1	-
Philadelphia, Pa.	304	202	68	24	6	4	8
Pittsburgh, Pa.§	42	31	7	2	1	1	4
Reading, Pa.	29	24	3	1	1	-	1
Rochester, N.Y.	113	90	15	4	3	1	8
Schenectady, N.Y.	21	18	2	1	-	-	-
Scranton, Pa.§	29	22	6	1	-	-	1
Syracuse, N.Y.	105	84	14	4	1	2	10
Trenton, N.J.	24	17	6	-	-	1	-
Utica, N.Y.	17	14	1	1	1	-	2
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,693	1,154	345	107	50	37	123
Akron, Ohio	42	32	7	3	-	-	3
Canton, Ohio	42	31	10	1	-	-	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	104	79	14	5	3	3	6
Cleveland, Ohio	119	65	39	9	2	4	5
Columbus, Ohio	185	123	34	21	3	4	11
Dayton, Ohio	117	87	23	2	5	-	7
Detroit, Mich.	186	90	56	22	11	7	17
Evansville, Ind.	54	39	9	4	1	1	4
Fort Wayne, Ind.	64	52	10	1	-	1	10
Gary, Ind.	17	8	4	3	2	-	1
Grand Rapids, Mich.	99	64	11	5	12	7	9
Indianapolis, Ind.	171	112	38	14	4	3	10
Lansing, Mich.	45	32	10	2	1	-	-
Milwaukee, Wis.	115	86	23	5	1	1	16
Peoria, Ill.	46	31	12	2	1	-	3
Rockford, Ill.	54	41	8	1	1	3	4
South Bend, Ind.	53	42	9	-	2	-	7
Toledo, Ohio	101	78	15	7	-	1	4
Youngstown, Ohio	79	63	13	-	1	2	3
W.N. CENTRAL	653	452	115	52	19	15	32
Des Moines, Iowa	49	34	11	2	1	1	4
Duluth, Minn.	30	21	6	1	2	-	4
Kansas City, Kans.	29	21	1	7	-	-	3
Kansas City, Mo.	U	U	U	U	U	U	U
Lincoln, Nebr.	41	32	8	1	-	-	3
Minneapolis, Minn.	147	104	24	13	2	4	4
Omaha, Nebr.	80	57	13	6	2	2	4
St. Louis, Mo.	108	55	26	17	8	2	-
St. Paul, Minn.	81	62	11	3	1	4	6
Wichita, Kans.	88	66	15	2	3	2	4
S. ATLANTIC	1,329	840	310	105	46	26	96
Atlanta, Ga.	141	89	32	10	7	3	-
Baltimore, Md.	197	104	60	21	6	6	22
Charlotte, N.C.	103	62	25	8	3	5	7
Jacksonville, Fla.	143	97	34	7	4	1	18
Miami, Fla.	117	78	24	9	5	1	17
Norfolk, Va.	41	21	7	5	4	3	1
Richmond, Va.	64	41	12	5	3	2	4
Savannah, Ga.	58	44	10	2	2	-	6
St. Petersburg, Fla.	54	41	8	2	2	1	5
Tampa, Fla.	182	120	43	14	3	2	14
Washington, D.C.	201	128	42	22	7	2	2
Wilmington, Del.	28	15	13	-	-	-	-
E.S. CENTRAL	840	580	160	62	27	10	60
Birmingham, Ala.	143	105	27	9	1	-	15
Chattanooga, Tenn.	96	75	17	2	1	1	2
Knoxville, Tenn.	85	62	19	1	1	2	2
Lexington, Ky.	67	43	8	11	5	-	4
Memphis, Tenn.	161	105	27	13	13	3	16
Mobile, Ala.	100	73	15	9	1	2	3
Montgomery, Ala.	43	31	8	3	1	-	7
Nashville, Tenn.	145	86	39	14	4	2	11
W.S. CENTRAL	1,363	841	275	126	88	35	86
Austin, Tex.	84	58	15	7	4	-	6
Baton Rouge, La.	44	23	15	5	1	-	4
Corpus Christi, Tex.	41	25	10	3	1	2	-
Dallas, Tex.	U	U	U	U	U	U	U
El Paso, Tex.	106	68	24	7	3	4	9
Ft. Worth, Tex.	138	91	31	9	4	3	5
Houston, Tex.	471	233	96	64	55	23	27
Little Rock, Ark.	62	33	12	11	4	2	3
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	219	160	38	14	6	1	17
Shreveport, La.	73	59	8	3	3	-	7
Tulsa, Okla.	125	91	26	3	5	-	8
MOUNTAIN	952	625	178	96	31	23	61
Albuquerque, N.M.	67	46	8	11	2	-	5
Boise, Idaho	43	28	9	4	2	-	4
Colo. Springs, Colo.	82	48	7	6	-	1	3
Denver, Colo.	114	71	24	12	4	3	11
Las Vegas, Nev.	248	164	55	19	5	5	11
Ogden, Utah	25	20	3	1	1	-	-
Phoenix, Ariz.	140	78	31	20	7	4	8
Pueblo, Colo.	21	18	2	-	1	-	1
Salt Lake City, Utah	112	72	22	8	3	7	12
Tucson, Ariz.	120	80	17	14	6	3	6
PACIFIC	1,849	1,304	355	128	34	25	128
Berkeley, Calif.	12	8	3	-	1	-	1
Fresno, Calif.	159	116	31	7	3	2	6
Glendale, Calif.	19	16	3	-	-	-	-
Honolulu, Hawaii	57	39	14	1	1	2	4
Long Beach, Calif.	62	46	12	4	-	-	8
Los Angeles, Calif.	447	301	84	46	12	4	28
Pasadena, Calif.	33	24	6	2	-	1	6
Portland, Oreg.	148	113	23	6	1	5	4
Sacramento, Calif.	188	140	29	11	5	3	17
San Diego, Calif.	166	110	42	7	3	3	20
San Francisco, Calif.	102	70	23	7	1	1	10
San Jose, Calif.	161	121	28	7	3	2	7
Santa Cruz, Calif.	28	19	4	5	-	-	3
Seattle, Wash.	112	76	20	12	2	2	10
Spokane, Wash.	49	36	7	5	1	-	2
Tacoma, Wash.	106	69	26	8	1	-	2
TOTAL	11,316¶	7,654	2,247	845	348	216	751

U: Unavailable. -:No reported cases.

*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

Contributors to the Production of the *MMWR* (Weekly)

Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.

State Support Team
Robert Fagan
Jose Aponte
Gerald Jones
David Nitschke
Scott Noldy
Jim Vaughan
Carol A. Worsham

CDC Operations Team
Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Patsy A. Hall
Mechele Hester
Felicia J. Perry
Pearl Sharp

Informatics

T. Demetri Vacalis, Ph.D.
Michele D. Renshaw
Erica R. Shaver

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/Publications/mmwr*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

Director, Centers for Disease Control and Prevention
Jeffrey P. Koplan, M.D., M.P.H.

Deputy Director for Science and Public Health, Centers for Disease Control and Prevention
David W. Fleming, M.D.

Director, Epidemiology Program Office
Stephen B. Thacker, M.D., M.Sc.

Editor, *MMWR* Series
John W. Ward, M.D.

Acting Managing Editor, *MMWR* (Weekly)
Teresa F. Rutledge

Writers-Editors, *MMWR* (Weekly)
Jill Crane
David C. Johnson

Desktop Publishing
Lynda G. Cupell
Morie M. Higgins

☆U.S. Government Printing Office: 2001-633-173/48247 Region IV

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333

FIRST-CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284

Official Business
Penalty for Private Use $300
Return Service Requested

9907 93036 L21224 0011
UNIVERSITY MICROFILMS
SERIALS ACQUISITION DEPT
300 NORTH ZEEB ROAD
ANN ARBOR MI 48103-1553